



Phone: (305) 306-7147  
Fax: (305) 442-9559  
Email: intake@clearwellinfusion.com

# FABRAZyme (agalsidase beta)

## PATIENT DEMOGRAPHICS

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ M:  F:  Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Email: \_\_\_\_\_  
Allergies: \_\_\_\_\_

## PRIMARY DIAGNOSIS

ICD-10 Code: \_\_\_\_\_

## DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

## PRE-MEDICATION

<input type="checkbox"/> Acetaminophen 1000mg PO	<input type="checkbox"/> Solu-Medrol 125mg IVP
<input type="checkbox"/> Diphenhydramine 25mg PO	<input type="checkbox"/> Solu-Cortef 100mg IVP
<input type="checkbox"/> Ceterizine 10mg PO	<input type="checkbox"/> Diphenhydramine 25mg IVP
<input type="checkbox"/> Loratadine 10mg PO	<input type="checkbox"/> Other: _____

## PRIMARY MEDICATION ORDER

### Dosage

1 mg/kg  
 Other: \_\_\_\_\_

### Patient Weight:

\_\_\_\_\_ lbs  
\_\_\_\_\_ kg

### Frequency

Every 2 weeks

## NOTES

\_\_\_\_\_

## ORDERING PROVIDER

Provider Name: \_\_\_\_\_ NPI: \_\_\_\_\_  
Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Office Contact: \_\_\_\_\_ Fax: \_\_\_\_\_  
Practice Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_